DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G282	A. BUILDING _____ B. WING _____	R 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-LAURELWOOD	200 LAURELWOOD DR SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A revisit was conducted on 5/11/21 for all previous deficiencies cited on 12/16/20. The following deficiencies have been corrected: W104, W227, W368, W447, and W481. The facility remained out of compliance in E006 and had new areas of non-compliance in W382 and W383.	E 000		
{E 006}	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be	{E 006}	E 006 (recite) This deficiency will be corrected by the following actions A. The facility will develop and maintain a emergency preparedness plan and it will be reviewed and updated annually. B. Strategies will be identified via the risk assessment and the plan will implement strategies the event of an emergency C. Strategies will be identified via the risk assessment and the plan will implement strategies the event of an emergency—to include but not limited to all potential risk that would directly impact a person the lives of the people living in the group home D. A method of communicating specific needs of the people served on site will be addressed E. Management will implement F. Management will in services staff on the plan annually G. Management will have the plan updated annually.	06.11.2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Cynthia Bradford Ass't Executive Director 6/22/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{E 006}	Continued From page 1 reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on policy review and staff interview, the facility failed to develop an emergency preparedness (EP) plan including and based upon a community and facility-based risk assessment utilizing an all-hazards approach. This had the potential to affect all clients (#1, #2, #3, #4, #5 and #6). The finding is: A review on 5/11/21 of the facility's submitted "Summary of Hazards Analysis, dated 2017, revealed the plan was created for their sister facility, at a different location. The summary was vague using a bar graph and identified the largest threat to the facility being technology. In the Plan of Correction binder contained an email from the	{E 006}		

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{E 006}	Continued From page 2 Program Director (PD) dated 1/07/21 which acknowledged that the performance analysis (PA) did not contain the risk assessment to determine how and why the information was collected. The PD also commented that the PA was done initially, 2-3 years ago and that they needed to contact RISK to request a new assessment. An interview on 5/11/21 with the PD revealed he would fax over to the Home Manager (HM) the current copy of the community-based risk assessment for review. An interview on 5/11/21 with the HM and Qualified Intellectual Disabilities Professional (QIDP) revealed they were unaware that the new community-based risk assessment was not specific to this home.	{E 006}		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, training records and staff interviews, the facility failed to ensure that the medication room remained locked to prevent unauthorized access. This had the potential to affect all clients in the home, (#1, #2, #3, #4, #5 and #6). The findings are: During noon observations of the medication administration on 5/11/21 at 12:22 PM, Staff A walked out of the medication room, in order to get Client #4, who uses a wheelchair. Staff B was	W 382	W.382 (. This deficiency will be corrected by the following actions: A. All medications will be locked and secured unless being administered. B. No medications will be left unattended. C. Staff will be in serviced on ensuring that all medication remains locked except during administration. D. Medication Monitor Closet sheets will be completed weekly. E. Site Supervisor will monitor one time a week. F. Qualified Professional will monitor one time a week.	07.11.2021

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W 382	Continued From page 3 making lunch and the Qualified Intellectual Disabilities Professional (QIDP) was assisting clients wash their hands before eating lunch. The medication closet was left open and the cabinet with medications was unlocked. The medications were inside of the cabinet. The door to the medication room was left open with the surveyor remaining inside alone for until 12:23 PM. An additional observation on 5/11/21 at 12:31 pm, Staff A walked out of the medication room, in order to get Client #5, who uses a wheelchair. Staff B and the QIDP remained occupied with the other clients. The medication cabinet, the door to the medication closet and the door to the medication room remained open for two minutes. Review on 5/11/21 of a training on Medication Administration, held on 12/30/20 showed that staff were instructed to do the following: Ensure medication closet is locked appropriately. Never leave open even if someone else is in the office. An interview on 5/11/21 with Staff A revealed normally the other staff bring the clients to the medication room, so that Staff C does not have to exit. An interview on 5/11/21 with the Home Manager (HM) indicated that everything is supposed to be locked up during med pass.	W 382		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area.	W 383		

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W 383	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations, training records and interviews, the facility failed to secure the key to the medication room, when authorized staff were not present. This had the potential to affect 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The findings are: During observations of the afternoon medication administration in the home on 5/11/21 from 12:18-12:40 PM, Staff A left the lock box to the medication closet open with the keys inside. Staff A walked out of the medication room twice, leaving the surveyor alone in the room, to get Clients #2 and #4. A review on 5/11/21 of the facility's 12/30/20 training on medication administration showed that staff were instructed to maintain medication key on person. An interview on 5/11/21 with Staff A revealed that normally she does not leave box unsecured during med pass. An interview on 5/11/21 with the Home Manager (HM) revealed that staff have been trained that everything must be locked up during med pass.	W 383	W.383 This deficiency will be corrected by the following actions: A. All medications will be locked and keys will be secured unless being administered. B. No medications will be left unattended. C. All mediation will be locked when not in use or when staff steps out of medication location D. Staff will be in serviced on ensuring that all medication remains locked except during administration. E. Staff will be in serviced protocol for securing keys to medication closet F. Medication Monitor Closet sheets will be completed weekly. G. Site Supervisor will monitor one time a week. H. Qualified Professional will monitor one time a week.	07.11.2021